Player Emergency Information Form

Player Information

First Name		Last Name	
Address			
City		Postal Code	
Date of Birth		Phone Number	

Emergency Contacts

Mother/Guardian	
Phone Number	
Cell Number	

Father/Guardian	
Phone Number	
Cell Number	

Alternate Contact

Name		Relationship	
Phone Number		Cell Number	

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Medical Information

This information is being provided voluntarily in accordance with the BSC Privacy Policy

Family Doctor		Phone Number	

Is player allergic to medications? If so, please list. _____

_____

Does player have other allergies (i.e. bee sting, food, environmental, etc.)? If so, please list. _____

_____

Does player suffer from any serious illnesses? (Please check)

□ Asthma □ Diabetes □ Epilepsy □ Other (please specify) _____

_____

Does player take any regular medication(s)? If so, please list. _____

_____

Does player wear contact lenses, glasses? □ YES □ NO

Does player have previous injuries / concussions (please include date(s): _____

_____

_____ _____

Signature Date

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